STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	
		155327	B. WIN	G		08/24/2	:011
NAME OF F	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
					COUNTY LINE RD S		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY I	NC	INDIA	NAPOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r the Investigation of	EO	0000	This plan ofi correctton is tto serv	0.35	
		r the Investigation of	FU	0000	Universitty Heightts Healtth and L		
	•	0094060, IN00095148,			Communitty's credible allegatton	_	
	and IN00095168				compliance.		
		D100004060					
	Complaint numb	-			Submission ofi tthis plan ofi corre	ctton	
	Unsubstantiated (due to lack of evidence.			does nott consttttutte an admissi	•	
					Universitty Heightts Healtth and L	_	
	Complaint numb	er IN00095148,			Communitty or itts managementt		
	Unsubstantiated	due to lack of evidence.			company thatt the allegations contained in the survey reportt	ic	
					ttrue and accuratte porttrayal ofi		
	Complaint numb	er IN00095168,			provision ofi nursing care and ott		
	Substantiated, Fe	ederal/State deficiencies			services in tthis fiacilittyNor does t		
	related to the alle	egations are cited at F309.			submission consttttutte an agreer	mentt	
					or admission ofi tthe survey		
	Unrelated deficie	ency cited at F323.			allegattons.		
		3					
	Survey dates: Ai	ugust 22, 23, 24, 2011					
	Facility number:	000220					
	Provider number						
	AIM number: 10						
	7 mivi namoci. 10	70207030					
	Survey team:						
	Linda Campbell,	DN					
	Linua Campoen,	KIN					
	Census bed type:						
		137					
		13/					
	Total: 137						
	a .						
	Census payor typ	oe:					
	Medicare: 24						
	Medicaid: 86						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: O2QM11 Facility ID: If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155327	B. WING			08/24/2	011
			D. 171111		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				COUNTY LINE RD S		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY IN	٧C		APOLIS, IN46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Other: 27						
	Total: 137						
	Sample: 8						
	These deficiencie	es also reflect state					
	findings cited in	accordance with 410 IAC					
	16.2.						
	Quality review co	ompleted on August 26,					
	2011 by Bev Fau						
F0309 SS=D	must provide the reto attain or maintal physical, mental, a in accordance with assessment and personal based on record facility failed to diabetes were proservices required for 2 of 4 diabete of 8. The resider numerous omissi	review and interview, the ensure residents with ovided the care and to manage their disease c residents in the sample ents' records contained ons of documentation sugar checks and insulin	F0:	309	F309-483.25 Provide Care and Services For Highestt Well Being I. Residentt#A and E now have accuratte documenttatton refiective sliding scale insulin administered accordance with physician orders Residentt#A and E's pastt30 day blood sugar/sliding scale insulin recordkeeping has been reviewed	in	09/23/2011
	Findings include	:			witth each residentt's respective attending physician.		
	reviewed on 8/22 record indicated	clinical record was 2/11 at 11:17 A.M. The the resident was admitted which included, but was			II. All residentts who have currentt sliding scale insulin physician orde have been identtfied.	rs	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: O2QM11 Facility ID: 000220

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155327 08/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1380 E COUNTY LINE RD S UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY INC INDIANAPOLIS, IN46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE All residentts past80 day blood not limited to, diabetes mellitus. sugar/sliding scale insulin recordkeeping has been reviewed A physician's order recapitulation, dated witth each residentt's respective August 2011, indicated: attending physician. "10/30/10 Accuchecks [fingerstick blood A systemic change will include sugar testing] 3 times a day. Call < (less that all than) 60 or > (greater than) 350..." dosages sliding scale insulin administered will be recorded on "Novolog (insulin). Inject subcutaneously the blood glucose log. per sliding scale: Before meals: < (less A systemic change will include than) 150 = 0 units: 151-200 = 2 units: that all sliding scale insulin blood 201-250 = 4 units: 251-300 = 6 units: glucose log documentation will be 301-350 = 8 units, > (greater than) 350discussed at Monday-Friday daily clinical meeting per nursing unit call MD..." manager. Identified concerns will be immediately addressed. "Blood Glucose Testing Logs" dated July 2011 indicated: Training will be provided to licensed nurse staff to review sliding scale insulin On 7/18/11 at 4:00 P.M. - The resident's administration/documentation blood glucose was recorded as 191 procedures. documentation was lacking to indicate the resident received 2 units of insulin as IV. ordered. The Director of Nursing and or designee will conduct weekly On 7/27/11 at 11:00 A.M. - The resident's documentation audit of 10 blood glucose was recorded as 211 resident blood glucose/sliding scale insulin logs x 12 months. documentation was lacking to indicate the resident received 4 units of insulin as Any identified concerns will be ordered. addressed. The results of these audits will be On 7/27/11 at 4:00 P.M. - Documentation discussed at the facility Quality was lacking to indicate the resident's Assurance Committee meeting. blood glucose had been checked as

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327		ľ	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/24/2011	
NAME OF 1	PROVIDER OR SUPPLIEI		<u> </u>	1	ADDRESS, CITY, STATE, ZIP CODE	L
UNIVER	SITY HEIGHTS HE	ALTH AND LIVING COMMUNITY	' INC		COUNTY LINE RD S APOLIS, IN46227	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG	ordered.	LISC IDENTIFTING INFORMATION)	-	IAG	Modifications of the following	
				will be adjusted as deemed		
		Testing Logs" dated			necessary.	
	August 2011 ind	licated:			Completion Date: September 2011.	er 23,
	On 8/1/11 at 7:0	0 A.M The resident's				
	_	as recorded as 320 -				
		vas lacking to indicate the				
	ordered.	18 units of insulin as				
	ordered.					
	On 8/2/11 at 8:0	0 A.M The resident's				
	_	as recorded as 234 -				
		vas lacking to indicate the				
	ordered.	1 4 units of insulin as				
	On 8/3/11 at 4:0	0 P.M The resident's				
		as recorded as 169 -				
		vas lacking to indicate the				
		d 2 units of insulin as				
	ordered.					
	Interview on 8/2	2/11 at 1:05 P.M. with				
	Unit Manager #2	2 indicated blood glucose				
		in administration should				
		on the blood glucose				
	testing logs.					
	2. Resident #E's	clinical record was				
	reviewed on 8/23/11 at 10:50 A.M. The					
	record indicated	the resident was admitted				
	I -	which included, but was				
	not limited to, di	iabetes mellitus.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	(X3) DATE COMP 08/24/ 2	LETED	
	PROVIDER OR SUPPLIER	II : ALTH AND LIVING COMMUNITY	-	1380 E	DDDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE
	August 2011, inc	ecks before meals and at					
	per sliding scale: bedtime: < 150 =	n). Inject subcutaneously Before meals and at 0 units tx: 151-200 = 2 4 units: 251-300 = 6 MD"					
	"Blood Glucose" 2011 indicated:	Testing Logs" dated July					
	blood glucose was documentation w	O P.M The resident's as recorded as 278 - vas lacking to indicate the 16 units of insulin as					
	blood glucose was documentation w	O P.M The resident's as recorded as 165 - vas lacking to indicate the 12 units of insulin as					
	blood glucose wa documentation w	:00 A.M The resident's as recorded as 258 - vas lacking to indicate the l 6 units of insulin as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		ľ	ILDING	ONSTRUCTION 00	(X3) DATE : COMPL 08/24/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u>.</u>		1	ADDRESS, CITY, STATE, ZIP CODE		
UNIVER	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	' INC		COUNTY LINE RD S APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL . LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
TAG	On 7/12/11 at 7: blood glucose w documentation v resident received ordered. On 7/12/11 at 11 blood glucose w documentation v resident received ordered. On 7/13/11 at 7:	200 A.M The resident's as recorded as 156 - was lacking to indicate the 12 units of insulin as 200 A.M The resident's as recorded as 167 - was lacking to indicate the 12 units of insulin as		TAG	DEFICIENCY)		DATE
	documentation v	vas lacking to indicate the 14 units of insulin as					
	blood glucose w documentation v	:00 A.M The resident's as recorded as 169 - was lacking to indicate the 12 units of insulin as					
	blood glucose w documentation v	00 A.M The resident's as recorded as 204 - was lacking to indicate the 14 units of insulin as					
	blood glucose w documentation v	:00 A.M The resident's as recorded as 175 - was lacking to indicate the 14 units of insulin as					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327		ľ	ILDING	NSTRUCTION 00	· ′	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER	IL R ALTH AND LIVING COMMUNITY		1380 E (DDRESS, CITY, STATE, ZIP COE COUNTY LINE RD S APOLIS, IN46227	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	ordered.						
	blood glucose w documentation v	00 P.M The resident's as recorded as 165 - was lacking to indicate the 12 units of insulin as					
	Documentation v	:00 A.M. and 4:00 P.M was lacking to indicate e checks had been done.					
	Documentation v	:00 A.M. and 4:00 P.M was lacking to indicate e checks had been done.					
	"Blood Glucose August 2011 ind	Testing Logs" dated icated:					
	blood glucose w documentation v	O P.M The resident's as recorded as 160 - was lacking to indicate the 12 units of insulin as					
	blood glucose w documentation v	O A.M The resident's as recorded as 185 - was lacking to indicate the 12 units of insulin as					
	blood glucose w	0 P.M The resident's as recorded as 260 - was lacking to indicate the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155327	B. WIN			08/24/2	011
		1	B. WII.		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	COUNTY LINE RD S		
UNIVER	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	INC	1	APOLIS, IN46227		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident received	d 6 units of insulin as					
	ordered.						
	On 8/6/11 at 9:0	0 P.M The resident's					
		as recorded as 190 -					
	_	vas lacking to indicate the					
		d 2 units of insulin as					
		1 2 units of moulin as					
	ordered.						
	0.0/0/11	0.1.16					
		0 A.M The resident's					
	_	as recorded as 196 -					
	documentation v	vas lacking to indicate the					
	resident received	d 2 units of insulin as					
	ordered.						
	On 8/9/11 at 11:0	00 A.M The resident's					
		as recorded as 183 -					
	_						
		vas lacking to indicate the					
		d 2 units of insulin as					
	ordered.						
	On 8/10/11 at 4:	00 P.M Documentation					
	was lacking to ir	ndicate the blood glucose					
	checks had been	done.					
	On 8/13/11 at 9:0	00 P.M The resident's					
		as recorded as 321 -					
	_	vas lacking to indicate the					
		d 6 units of insulin as					
		a o units of msulfit as					
	ordered.						
		00 P.M The resident's					
	blood glucose w	as recorded as 170 -					
	documentation v	vas lacking to indicate the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155327	B. WIN			08/24/20	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			COUNTY LINE RD S		
UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNIT			/ INC	1	IAPOLIS, IN46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	nn outen par av av on connection		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE	DATE
	resident received	12 units of insulin as					
	ordered.						
	ordered.						
	On 8/10/11 at 0:0	00 P.M Documentation					
	_	dicate the blood glucose					
	checks had been	uone.					
	On 8/20/11 at 9:0	00 P.M Documentation					
		dicate the blood glucose					
	checks had been	<u> </u>					
	checks had been	done.					
	On 9/21/11 of 11	:00 A.M The resident's					
	_	as recorded as 239 -					
		vas lacking to indicate the					
		4 units of insulin as					
	ordered.						
		:00 A.M The resident's					
	blood glucose wa	as recorded as 186 -					
	documentation w	as lacking to indicate the					
	resident received	12 units of insulin as					
	ordered.						
	On 8/22/11 at 4:0	00 P.M The resident's					
		as recorded as 166 -					
	~	vas lacking to indicate the					
		_					
	resident received 2 units of insulin as						
	ordered.						
	Interview on 8/2	2/11 at 1:05 P.M. with					
	Interview on 8/22/11 at 1:05 P.M. with						
	1	2 indicated blood glucose					
		n administration should					
		on the blood glucose					
	testing logs.						

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLI	ETED
		155327	B. WING			08/24/20	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
		ALTH AND LIVING COMMUNITY II	VIC.		COUNTY LINE RD S		
			NC .		APOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
F0323 SS=D	facility policy an 10/2010, provide identified as curr a Fingerstick Glu "The person pershould record the in the resident's reblood sugar results sliding scale covers and the interest of	rent, and titled "Obtaining acose Level" indicated erforming this procedure of following information medical record:the attsif the resident is on erage" The relates to Complaint The resident is as free of accident sible; and each resident expervision and assistance	F0	323	F323-483.25 (h) Free ofi Accidentt Hazards/Supervision/Devices I. Residentt#D's non skid sttrips dyce personal safietty alarmsselfireleasi safietty beltts are in place and fiuncttoning. II. All residents with fall interventions in place will be identified. An audit will be conducted to verify implementation of the residents.	ng	09/23/2011

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Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155327			LDING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/24/2011		
	PROVIDER OR SUPPLIER SITY HEIGHTS HEA	LITH AND LIVING COMMUNITY I	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S Y INC INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	falls relate strips, alar	ed to non-skid ms, and			fall prevention plan of care. III. A systemic change will inclu implementation of licensed n	nurse	
	residents v	on for 1 of 3 with history of ample of 8. #D).			shift to shift documentation to verify, monitor, and superviss implementation resident fall prevention interventions. Identified concerns will be immediately addressed. Training will be provided to licensed nurse, and C.N.A. s	e	
	Findings include:				to review fall prevention and management procedures inclusive of strategies to supervise at risk residents at monitor implementation fall prevention interventions.	nd to	
	On 8/23/11 at 9:40 A.M., Resident #D was observed sitting in the hallway in a wheelchair. The resident's feet were on foot pedals, the wheelchair back was slightly tilted backward, there was a seat belt in place, and there was a pressure alarm in place.				The Director of Nursing and designee will conduct weekly observation and documentat fall prevention audits for 10 residents x 12 months. Any identified concerns will addressed. The results of these audits we discussed at the facility Qual Assurance Committee meeti Modifications of the following will be adjusted as deemed necessary. Completion Date: September 2011.	y tion be will be lity ng. g plan	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		A. BUI	ILDING	NSTRUCTION 00	(X3) DATE : COMPL 08/24/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 1380 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S	00/2 //2	•
(X4) ID		ALTH AND LIVING COMMUNITY TATEMENT OF DEFICIENCIES	INC	ID	APOLIS, IN46227 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	The reside	ent was sitting					
	on a 3-inc	h thick, black					
	gel cushio	n that was not					
	wedged. T	There were rear					
	anti-tipper	rs in place. The					
	resident w	as taken to his					
	room and	two staff					
	members	stood the					
	resident.	The alarms					
	sounded.	Observation of					
	the room i	indicated there					
	were no n	on-skid strips					
	on the floo	or.					
	Interview	on 8/23/11 at					
	9:50 A.M.	., with Unit					
	Manager ((UM) #1					
	indicated	the resident's					
	room had	been					
	remodeled	d and "we need					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		ILDING	NSTRUCTION 00	(X3) DATE COMPI 08/24/2	LETED	
	PROVIDER OR SUPPLIER	II S ALTH AND LIVING COMMUNITY	1380 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S APOLIS, IN46227	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	to put the	non-skid strips				
	in place."	She indicated				
	the strips	should have				
	been place	ed on the floor				
	in the resi	dent's room.				
	On 8/23/1	1 at 10:10				
	A.M., dur	ing an				
	observatio	on with the				
	Assistant	Director of				
	Nursing (A	ADON),				
	Resident #	D was sitting				
	the wheel	chair in his				
	room. The	ere was Dycem				
	observed	between the				
	cushion as	nd the seat of				
	the wheel	chair. The				
	ADON sta	ated "That				
	won't do a	ny good."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327			A. BUI	LDING	NSTRUCTION 00	cc	ATE SURVEY MPLETED 24/2011
	PROVIDER OR SUPPLIER		B. WIN	1380 E	DDRESS, CITY, STATE, ZIF COUNTY LINE RD S APOLIS, IN46227	CODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERNCED TO THE DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	Resident 7	#D's clinical					
	record wa	s reviewed on					
	8/23/11 at	8:40 A.M.					
	The recor	d indicated the					
	resident was admitted						
	with diag	noses which					
	included, but were not						
	limited to, progressive						
	Parkinson	's disease,					
	dementia	with agitation					
	and aggre	ssion, frequent					
	falls, wan	dering at night,					
	increased	weakness,					
	decreased	mobility,					
	insomnia,	neuropathy,					
	and peripl	neral edema.					
	A Minimu	ım Data Set					
	(MDS) Q	uarterly					
	Assessme	nt, dated					
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	O2QM1	1 Facility I	D: 000220 If o	continuation sheet	Page 14 of 73

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2	2) MULTIPLE CO			(X3) DATE S COMPL	
AND PLAIN	OF CORRECTION	155327		BUILDING	00		08/24/2	
			В. \	WING STREET A	ADDRESS, CITY, STA	ATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				COUNTY LINE			
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMU	JNITY INC	INDIAN	IAPOLIS, IN4622	27		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	,	ID PREFIX		PLAN OF CORRECTION /E ACTION SHOULD BE		(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FUL LSC IDENTIFYING INFORMATIO		TAG	CROSS-REFERENCE	ED TO THE APPROPRIAT	E	DATE
	6/22/11, in	ndicated the						
	resident w	as severely						
	impaired in cognitive							
	decision-making skills,							
	required e							
	•	n physical						
	assistance	for transfer						
	and toilet	use, required						
		one-person						
	1 2	ssistance for						
		n, balance was						
	_	and was only						
	able to sta	bilize with						
		sistance, and						
	had one fa	all without						
	injury.							
		an's orders						
	*	tion, dated						
	August 20	11, indicated						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event II	D: O2QN	√11 Facility	ID: 000220	If continuation sh	eet Pa	ge 15 of 73

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			IULTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE S COMPL 08/24/20	ETED	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/24/20	011
		ALTH AND LIVING COMMUNITY	INC		COUNTY LINE RD S APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	"4/5/11 Check safety devices for functioning						
	and position	oning every					
	shift (6-2,	2-10, 10-6)"					
	Fall risk a	ssessments					
	indicated:						
	3/10/11 - 1	the resident					
	had intern	nittent					
	confusion	, had 3 or more					
	falls in the	e previous 3					
	months, w	as chair					
	bound, an	d had balance					
		The score was					
	•	ing high risk					
	for fall.	<i>8 8</i> -					
	6/14/11 - 1	the resident					
	had intern						
	1144 11110111						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	IULTIPLE CO	NSTRUCTION 00		X3) DATE S COMPL	
AND PLAN OF CORRECTION	155327	A. BU B. WI	ILDING			08/24/2011		
			D. W11		ADDRESS, CITY, STATE,	ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1380 E	COUNTY LINE RD	S		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUN	ITY INC	INDIAN	APOLIS, IN46227			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE AC			(X5)
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	E	COMPLETION DATE
	confusion	, had 3 or more						
	falls in the previous 3							
	months, was chair							
	bound, and	d had balance						
	_	The score was						
		ing high risk						
	for fall.							
	8/2/11 - th	ne resident had						
	intermitte	nt confusion,						
	had 3 or n	nore falls in the						
	previous 3	3 months, was						
	chair bour	nd, and had						
	balance pr	roblems. The						
	score was	20 indicating						
	high risk f	for fall.						
	A resident	t care plan,						
	dated 10/18/10, indicated							
	"Reside	nt at risk for						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	O2QM1	 Facility I 	ID: 000220	If continuation she	eet Pac	ge 17 of 73

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER SITY HEIGHTS HEA	IL	_!	STREET A 1380 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	falls due to weakness and decreased mobility,						
	diagnosis	of Parkinson's					
	and Deme	entiaApply					
	non-skid f	footwear before					
	transfers	.call light					
	within rea	chencourage					
	resident to	use call					
	lightplac	ce personal					
	items with	nin reachPT					
	(physical	therapy)/OT					
	(occupation	onal therapy) as					
	ordereda	activities to					
	look at act	tivity interest					
	and help to	o provide					
	activities 1	that can be					
	done at ni	ghtPSA					
	(personal	safety alarm)					
	to bed and	l chair"					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER	 - ALTH AND LIVING COMMUNITY	1380 E	COUNTY LINE RD S APOLIS, IN46227	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	A Physica	l Therapy				
	"Plan of Treatment,"					
	dated 2/18	3/11, indicated				
	"Unable	to perform				
	advanced	balance test				
	and is thus	s high fall				
	riskdem	onstrates				
	sitting bal	ance of F-				
	(fair-) stat	ic (able to				
	maintain s	static balance				
	with UE [upper				
	extremity]				
	support	Frunk leans to				
	the right a	and head				
	forward	demonstrates				
	standing b	palance of P+				
	(poor+) st	atic (able to				
	maintain b	palance with				
	minimum	assistance)"				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			IULTIPLE CO ILDING	ONSTRUCTION 00	(X3) DATE SU COMPLE 08/24/20	TED	
		199927	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	06/24/20	11
	PROVIDER OR SUPPLIER			1380 E	COUNTY LINE RD S		
		ALTH AND LIVING COMMUNITY	'INC		APOLIS, IN46227		710
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	•	TAG	DEFICIENCY)		DATE
	Nurses' notes indicated						
	the resident removed the						
	seat belt a	larm,					
	attempted	to transfer self					
	and/or am	bulate by self					
	on 3/6/11,	3/7/11,					
	3/19/11, a	nd 3/20/11.					
	A nurses'	note, dated					
	3/30/11 at	11:05 A.M.,					
	indicated	"CN (charge					
	nurse) ale	rted per DON					
	(Director	of Nursing)					
	that res (re	esident) was on					
	the floor.	Res found on					
	floor on k	nees @					
	bedside pe	er CN0 (no)					
	OA's (open areas) or apparent injuries						
	notedNo	on-skid strips					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	(X3) DATE COMPI 08/24/2	LETED	
	PROVIDER OR SUPPLIER	II S ALTH AND LIVING COMMUNITY	-	1380 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S APOLIS, IN46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	placed @	bedside as					
	safety intervention"						
	Documen	tation was					
	lacking re	lated to a bed					
	alarm beir	ng in place and					
	functionin	g at the time of					
	the fall.						
	An "Interd	disciplinary					
	Team Mee	eting Fall					
	Interventi	ons" form,					
	dated 3/31	1/11, indicated					
	"3/30/11	@ 11:05 AM,					
	Resident f	found in room					
	on knees	.Dates of					
	previous f	falls: 3/30/11;					
	3/10; 2/16	5; 1/24;					
	1/18unw	vitnessedPrev					
	ention dev	vices in use					
	prior to fa	ll: Personal					
							l

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	i '	ESURVEY PLETED 2011	
	PROVIDER OR SUPPLIER	II S ALTH AND LIVING COMMUNITY		1380 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	Safety Ala	arm Bed chair					
	seatbeltNew						
	intervention	on: non-skid					
	strips to fl	oorContinue					
	current sa	fety					
	intervention	ons. Non-skid					
	strips to fl	oor. Will					
	continue t	o monitor et					
	(and) F/U	(follow up) as					
	needed"						
	Documen	tation was					
	lacking to	indicate the					
	alarm was	functioning at					
	the time o	f the fall.					
	An undate	ed resident fall					
	care plan	provided by					
	the ADON	N indicated					
	"3/30/11	non-skid					
	strips to fl	oor @					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
155327			B. WIN	LDING NG		08/24/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	/ INC		APOLIS, IN46227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	1
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	bedside"						
	A nurses'	note, dated					
	4/2/11 at 4	4:30 P.M.,					
	indicated	"Resident					
	lowered so	elf to floor					
	from w/c	(wheelchair)					
	and began	crawling on					
	floor up h	allway. No					
	injuries ar	nd alarm did					
	not sound	"					
	An "Interd	disciplinary					
	Team Med	eting Fall					
	Interventi	ons" form,					
		1/11, indicated					
		(a) 11:05 AM,					
		found in room					
	on knees						
	previous i	falls: 3/30/11;					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		A. BU	ILDING	NSTRUCTION 00	(X3) DATE COMPI 08/24/2	LETED	
	PROVIDER OR SUPPLIER		B. WII	1380 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S APOLIS, IN46227	100/21/2	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	3/10; 2/16	5; 1/24;					
	1/18unwitnessedPrev						
	ention dev	vices in use					
	prior to fa	ll: Personal					
	Safety Ala	arm Bed chair					
	seatbelt]	New					
	intervention	on: non-skid					
	strips to fl	loorContinue					
	current sa	fety					
	intervention	ons. Non-skid					
	strips to fl	loor. Will					
	continue t	o monitor et					
	(and) F/U	(follow up) as					
	needed"						
	Documen	tation was					
	lacking to	indicate the					
	alarm was	s functioning at					
	the time o	f the fall.					
	An undate	ed resident fall					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		Ì	ILDING	NSTRUCTION 00	(X3) DATE COMP 08/24/2	LETED	
	PROVIDER OR SUPPLIER	II S ALTH AND LIVING COMMUNITY	-	1380 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S APOLIS, IN46227	I	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	care plan	provided by					
	the ADON indicated						
	"3/30/11	non-skid					
	strips to fl	loor @					
	bedside'	1					
	A nurses'	note, dated					
	4/11/11 at	10:30 A.M.,					
	indicated	"resident sliped					
	(sic) hims	elf down from					
	his w/c to	his knees on					
	the floor.	0 (no)					
	injuriesl	Resident was					
	combative	e c (with) staff					
	and non c	ompliant"					
	Documen	tation was					
	lacking to	indicate if an					
	alarm was	s on and					
	functionin	g at the time of					
	the fall.	_					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			MULTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE COMPI	LETED		
		155327	B. WI			08/24/2	2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S					
_		ALTH AND LIVING COMMUNITY	INC	ID	APOLIS, IN46227		(7/5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		disciplinary						
	Team Mee	eting Fall						
	Interventi	ons" form,						
	dated 4/12	2/11, indicated						
	"4/11/11	@ 10:30 AM,						
	Res was noted lowering							
	self to floor & crawling							
	into BR							
	(bathroom	n)witnessed						
	Prevention	n devices in						
	use prior t	to fall:						
	Personal S	Safety						
	AlarmN	ew						
	intervention	on: (the form						
	was blank	t)UM (unit						
	manager)	to conduct						
	staff ed (e	ducation) c						
	(with) CN	A re:						
	approach/	reapproach of						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	(X3) DATE COMP 08/24 /2	LETED	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	Į.	
UNIVER	SITY HEIGHTS HE	ALTH AND LIVING COMMUNITY	' INC		COUNTY LINE RD S APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	res, safe use of lifts (2						
	staff pres	ent), et 2					
	caregiver	s when res					
	becomes	combative"					
	Documen	tation was					
	lacking to	indicate if the					
	alarm was	s functioning at					
	the time of	of the fall.					
	An undate	ed resident fall					
	care plan	provided by					
	the ADO	N indicated					
	"4/12/1	1 Staff to					
	reapproac	ch res when he					
	is agitated	d/combative"					
	Nurses' no	otes indicated:					
	4/11/11 at	t 9:00 P.M.,					
	"Res ha	s been up in					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	ľ	E SURVEY PLETED 2011			
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE				
UNIVER	SITY HEIGHTS HE	ALTH AND LIVING COMMUNITY	INC	1380 E COUNTY LINE RD S NC INDIANAPOLIS, IN46227					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF T		D BE	(X5) COMPLETION DATE		
	w/c c (wi	th) alarm on &							
	has tried	to stand up							
	sounding	alarm"							
	4/12/11 a	t 12:00 A.M.,							
	"Res note	ed crawling on							
	floor fron	n room into							
	hallway.]	Res did not							
	know how	w he ended up							
	in hallwa	y on floorRes							
	bed was i	n low position							
	but bed al	larm was not in							
	place"	The resident							
	_	no injuries.							
		J							
	An "Inter	disciplinary							
	Team Me	1							
		ions" form,							
		2/11, indicated							
	"4/12/1	,							
	'1 /1 <i>L</i> /1	1 12 ANVI,							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155327		A. BU	ILDING	NSTRUCTION 00	(X3) DATE COMPI 08/24/2	LETED			
	PROVIDER OR SUPPLIER		B. WING GO/2-72511 STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN46227						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
	Resident of	crawling on							
	floor in hallway in front								
	of								
	roomun	witnessedPre							
	vention de	evices in use							
	prior to fa	ll: Personal							
	Safety AlarmNew								
	intervention	on: 30 min							
	(minute) o	checks							
	(indicated	by							
	checkmar	k)UM to							
	conduct st	taff ed							
	(education	n) c (with)							
	CNA; q (e	every) 15 min							
	checks (in	dicated by							
	checkmar	k) x 72o (72							
	hours); O'	Γ to F/U re:							
	(regarding	g) w/c							
	positionin	g"							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 08/24/2	ETED		
	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S Y INC INDIANAPOLIS, IN46227					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ed resident fall		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΝΈ	(X5) COMPLETION DATE	
	care plan provided by							
	the ADON indicated							
	document	ation was						
	lacking re	lated to any						
	new interv	ventions						
	implemented to prevent							
		the 4/12/11						
	fall.							
	the resident transfer set the seat be leaned for wheelchair 4/17/11, 4 4/22/11, 4	rward in the r on 4/13/11, /21/11, /28/11, /30/11, 5/2/11,						

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155327	B. WIN			08/24/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S	
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	INC		APOLIS, IN46227	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
TAG	5/7/11. A nurses' a 5/10/11 at indicated shift in diduring act appears to	ivities. Res have 0 (no)		TAG	DEFICIENCY)	DATE
		Res c (with) tempts before				
		asten belt and				
	get up"					
	(sic)," dated indicated name) wa					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION		(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155327	A. BUII		00		08/24/2	
		-	B. WIN		DDRESS, CITY, STATE, Z	ZIP CODE	·· -	
NAME OF P	ROVIDER OR SUPPLIER				COUNTY LINE RD			
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	/ INC	INDIAN	APOLIS, IN46227			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN O (EACH CORRECTIVE ACT			(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO DEFICIENCE	THE APPROPRIAT	E	COMPLETION DATE
	on the half	lway giving						
	medication	ns to other						
	residents.	The activies						
	(sic) assistant came and							
	got me and said							
	(Resident name) fell. I							
	went to the dining hall							
	and by that time							
	(Resident	name) was						
	back in his	s w/cWas a						
	restraint in	n use during						
	the fall:s	seat belt/waist						
	restraint	alarm sounded						
	during the	fallfound on						
	floor							
	unwitness	edgetting up						
	from							
	chair/whe	elchairThe						
	footwear a	at the time of						
	the incide	nt						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	L O2QM11	Facility I	D: 000220	If continuation sh	neet Pa	ge 32 of 73

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155327		LDING	00	08/24/20	
		100021	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 00:2 :: 20	
NAME OF P	PROVIDER OR SUPPLIER				COUNTY LINE RD S		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	INC	INDIAN	IAPOLIS, IN46227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	was:Slip	ppersRes					
	tried to stand up out of						
	w/cInstruct staff to						
	keep resident in view						
	when out	of her/his					
	roomInstruct staff to						
	increase staff supervision						
	to every 6	0 minutes"					
	_						
	An undate	ed resident fall					
	care plan	provided by					
		N indicated					
	document	ation was					
	lacking re	lated to any					
	new interv	ventions					
	implemen	ted to prevent					
	-	the 5/10/11					
	fall.						
	A "Therap	by					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì		NSTRUCTION 00		(X3) DATE : COMPL		
		155327	A. BUII B. WIN				08/24/2		
NAME OF P	PROVIDER OR SUPPLIEF	<u> </u>			DDRESS, CITY, STATE		<u> </u>		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNIT	Y INC	INC INDIANAPOLIS, IN46227					
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAI (EACH CORRECTIVE A	N OF CORRECTION		(X5)	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED DEFICIE	TO THE APPROPRIAT	E	COMPLETION DATE	
	Recomme	endation for							
	Nursing R	Rehab," dated							
	5/9/11, indicated								
	"Wheelchair								
	positioning: encourage								
	patient to propel								
	duel-axle wheelchair,								
	(seat wedged) and T-gel								
	checkerbo	oard-style seat							
	cushion w	ith rear							
	anti-tippe	rs, using arms							
	& legs c (with)							
	verbal/tac	tile cues for							
	hand plac	ement &							
	initiator a	nd							
	verbal/vis	ual cues to use							
	LEs (lowe	er extremities)							
	when tran	sporting							
	patient, us	se elevating							
	foot pedal	ls."							
DODLY CLES	5(7(02.00) P				D 000	TO			
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	O2QM11	Facility II	D: 000220	If continuation sl	neet Pa	ge 34 of 73	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			MULTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE COMPI	LETED			
		155327	B. WI			08/24/2	2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S						
_		ALTH AND LIVING COMMUNITY TATEMENT OF DEFICIENCIES	INC	ID I	APOLIS, IN46227		(V5)		
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E	(X5) COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE		
	A O								
	An Occup								
	Therapy "	Plan of							
	Treatment	t," dated 5/9/11,							
	indicated	"OT							
	(occupation	onal therapy)							
	continues to recommend								
	use of ele	vating foot							
	pedals for	transporting							
	patient. H	owever, when							
	patient is	left alone in							
	hallway a	nd he is alert,							
	OT recom	mends							
	removal o	f foot pedals							
	and encou	rage w/c							
	propulsion	n using B							
	(bilateral)	UEs (upper							
	extremitie	es) and B							
	(bilateral)	LEs (lower							
	extremitie	es)Patient							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		ĺ	LDING	ONSTRUCTION 00	(X3) DATE COMPL 08/24/2	LETED		
	PROVIDER OR SUPPLIER SITY HEIGHTS HEA	IL	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S Y INC INDIANAPOLIS, IN46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	fitted with	dual axle (seat						
	lowered in the back and							
	raised in the front) to							
	deter sit-si	tand unassisted						
	and enable	e patient to						
	propel w/c using B UEs							
	and B LEs. Patient also							
	has a self	release velcro						
	lap safety	belt with PSA						
	alarm of v	which he had						
	been using	g and able to						
	remove or	n command.						
	Patient wa	as also fitted						
	with 1"							
	checkerbo	oard-style						
	pressure re	elief seat						
	cushion fo	or						
	buttocks/I	LEs. OT						
	continues	to recommend						
	use of elev	vating foot						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL		
		155327	A. BUI B. WIN	LDING NG		08/24/2	
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	INC		COUNTY LINE RD S IAPOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	pedals for transporting						
	patient"						
	A nurses'	note, dated					
	5/22/11 at	2:45 A.M.,					
	indicated	"PSA sounding					
	- upon ent	ering resident's					
	•	dent found on					
	,	to bed sitting					
		bed control.					
	Bed in hig	gh position. 0					
	(no) reddr	ness (sic) or					
	injuries no	oted to					
	buttocks						
	An "Interd	disciplinary					
	Team Mee	1 3					
		ons" form,					
		3/11, indicated					
		(a) 2:45 AM,					
	<i>J 44 </i> 11	. (w, 2.73 AIVI,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	(X3) DATE COMPL	LETED	
	PROVIDER OR SUPPLIER SITY HEIGHTS HEA	IL	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	found on t	floor next to					
	bed sitting	g on bed					
	controlu	nwitnessedP					
	revention	devices in use					
	prior to fa	ll: (The form					
	was blank)New					
	intervention	on: 15 min					
	checks (in	dicated by					
	checkmar	k); unplug bed					
	when res i	in bedoffer					
	HS (bedti	me) snack;					
	unplug be	d when res is					
	in bed"						
	An Accide	ent					
	Investigat	ion Form					
	Unusual C	Occurences					
	(sic)," date	ed 5/22/11,					
	indicated	"Alarm					
	sounding	- left nurses					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155327		A. BUI	ILDING	NSTRUCTION 00	(X3) DATE SU COMPLE 08/24/20	TED
		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S			1	
(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
station &	found resident					
sitting on	floor next to					
bed on but	tt sitting on					
bed contro	ol & bed in					
high posit	ionalarm					
sounded d	uring the					
fallfound	d on floor					
unwitness	edgetting out					
of bedTl	he footwear at					
the time o	f the incident					
was:Plai	in					
socksRe	esident was					
sitting on	bed control					
which may	y have raised					
the bed af	ter resident					
was sitting	g on floor15					
min check	s (indicated by					
checkmarl	k)Bed in low					
& unplugg	ged when					
resident in	n bed					
	summary s Summary s Summary s Summary s (EACH DEFICIENT REGULATORY OR station & sitting on bed on but bed control high posit sounded d fallfound unwitness of bedT the time of was:Plain socksRe sitting on which may the bed af was sitting min check checkmark & unplugg	DEPTIFICATION NUMBER: 155327 ROVIDER OR SUPPLIER	ROVIDER OR SUPPLIER ITY HEIGHTS HEALTH AND LIVING COMMUNITY INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Station & found resident sitting on floor next to bed on butt sitting on bed control & bed in high positionalarm sounded during the fallfound on floor unwitnessedgetting out of bedThe footwear at the time of the incident was:Plain socksResident was sitting on bed control which may have raised the bed after resident was sitting on floor15 min checks (indicated by checkmark)Bed in low & unplugged when	ROVIDER OR SUPPLIER TO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Station & found resident sitting on floor next to bed on butt sitting on bed control & bed in high positionalarm sounded during the fallfound on floor unwitnessedgetting out of bedThe footwear at the time of the incident was:Plain socksResident was sitting on bed control which may have raised the bed after resident was sitting on floor15 min checks (indicated by checkmark)Bed in low & unplugged when	ROVIDER OR SUPPLIER ITY HEIGHTS HEALTH AND LIVING COMMUNITY INC SUMMARY STATEMENT OF DEFICIENCES (EACH) DEFICIENCY MUST BE PERCEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) Station & found resident sitting on floor next to bed on butt sitting on bed control & bed in high positionalarm sounded during the fallfound on floor unwitnessedgetting out of bedThe footwear at the time of the incident was:Plain socksResident was sitting on bed control which may have raised the bed after resident was sitting on floor15 min checks (indicated by checkmark)Bed in low & unplugged when	ROUTDER OR SUPPLIER ROUTDER OR SUPPLIER ROUTDER OR SUPPLIER ROUTDER OR SUPPLIER RECHARD SECONDAY LINE BE PERCEDED BY FULL RECHARDS OR SUPPLIER SUMMARY STATEMENT OF DEHECKICES (EACH DEFICIENCY MUST BE PERCEDED BY FULL RECHARDS OR SUPPLIER SITTY HEIGHTS HEALTH AND LIVING COMMUNITY INC SUMMARY STATEMENT OF DEHECKICES (EACH DEFICIENCY MUST BE PERCEDED BY FULL RECHARDS OR LISC IDENTITY NO. INFORMATION) STATEMENT OF THE PROPERTY OF DEHECKICES (EACH DEFICIENCY MUST BE PERCEDED BY FULL RECHARDS OR LISC IDENTITY NO. INFORMATION) STATEMENT OF THE PROPERTY OF THE PROPERY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		ĺ	ILDING	NSTRUCTION 00	ì í	E SURVEY PLETED '2011	
	PROVIDER OR SUPPLIER	II : ALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	unsupervi	sed"					
		ed resident fall					
	care plan	provided by					
	the ADON	N indicated					
	"15 min	checks					
	(indicated	by					
	checkmar	k)unplug bed					
	control wl	hen res is in					
	bedstaff	to offer hs					
	snack"						
	Interview	on 8/23/11 at					
	9:40 A.M	., with UM #1					
	indicated	the bed control					
	should ha	ve been left out					
	of reach o	f the resident					
	while in b	ed.					
	Nurses' no	otes indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	(X3) DATE COMPI 08/24/2	LETED		
	PROVIDER OR SUPPLIER	LALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE	
	the reside	nt attempted to						
	stand unassisted and/or							
	removed t	the seat belt on						
	6/10/11 ar	nd 6/11/11.						
	A nurses'	note, dated						
	6/12/11 at	6:45 P.M.,						
	indicated	"While in						
	MDR (ma	in dining						
	room) resi	ident leaned						
	forward in							
	slipped or	nto knees on						
	floor - rep	orted to this						
	nurse - PS	SA sounded						
	while a nu	irse and aid						
	(sic) were	assisting						
		ff the floor						
	resident b	ecame						
		e and threw a						
	beverage							
		(no)						

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION		(X3) DATE S COMPL	
AND LAN	OI CORRECTION	155327	A. BUI B. WIN	LDING	00		08/24/2	
			B. WIN		DDRESS, CITY, STATE, 2	ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1380 E COUNTY LINE RD S				
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNIT	Y INC	INDIAN	APOLIS, IN46227			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN ((EACH CORRECTIVE ACT			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO DEFICIEN	THE APPROPRIAT	E	DATE
	apparent i	njuries noted at						
	this time	."						
	An "Interc	disciplinary						
	Team Mee	eting Fall						
	Intervention	ons" form,						
	dated 6/13	3/11, indicated						
	"6/12/11	@ 6 PM res						
	was leanir	ng forward in						
	w/c in MI	OR, slipped out						
	of w/c on	to						
	kneesPro	evention						
	devices in	use prior to						
	fall: (The	form was						
	blank)N	ew						
	intervention	on: pain assess						
	(assessme	nt) done; 15						
	min check	s (indicated by						
	checkmarl	k)UM to						
	check (inc	licated by						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	 O2QM1 ²	1 Facility I	D: 000220	If continuation sh	neet Pag	ge 42 of 73

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	ľ	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER	ALTH AND LIVING COMMUNITY	•	1380 E	DDRESS, CITY, STATE, ZIP COD COUNTY LINE RD S APOLIS, IN46227	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	checkmar	k) safety belt et					
	(and) PSA"						
	An Accide Investigat Unusual (sic)," dat indicated feeding re (Resident went off s (Resident him to sto but he kep forward th (sic) on the grounda during the floor with	ent ion Form Occurences ed 6/12/11, "I was esidents then name) alarm o I was saying name) to get p getting up ot leaning nen he slipt					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		ĺ	IULTIPLE CO ILDING	NSTRUCTION 00	COMPLI	ETED	
		155327	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	08/24/20	711
NAME OF F	PROVIDER OR SUPPLIER						
		ALTH AND LIVING COMMUNITY	'INC	INDIAN	APOLIS, IN46227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE .	DATE
	footwear at the time of						
	the incident						
	was:Slip	ppersInstruct					
	staff to us	e a position or					
	pressure c	hange					
	alarmIns	struct staff to					
	keep resid	lent in view					
	when out	of her/his					
	roomIns	struct staff to					
	put reside	nt to bed when					
	he/she is t	ired15 min					
	checks (in	dicated by					
	checkmar	k) x 72o (72					
	hours)"						
	An undate	ed resident fall					
	care plan	provided by					
	the ADON	N indicated					
	document	ation was					
	lacking re	lated to any					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO	INSTRUCTION 00	(X3) DATE : COMPL		
		155327	B. WIN	NG		08/24/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	' INC		APOLIS, IN46227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .	DATE
	new interv	ventions					
	implemen	ted to prevent					
	falls after	the 6/12/11					
	fall.						
	A nurses'	note, dated					
	6/14/11 at	2:00 P.M.,					
	indicated	"Res found					
	crawling of	on the floor at					
	11:10 A.M	1. 0 (no)					
	apparent (sic) injury @					
	this time	."					
	Document	tation was					
	lacking re	lated to an					
	alarm beir	ng in place and					
	functionin	ıg.					
	An "Intero	disciplinary					
	Team Mee	1					
		ons" form,					
		,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327		A. BUI	ILDING	ONSTRUCTION 00	(X3) DATE COMPI 08/24/2	LETED	
		100021	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/24/2	.011
	PROVIDER OR SUPPLIER		1380 E COUNTY LINE RD S				
		ALTH AND LIVING COMMUNITY	INC		APOLIS, IN46227		(1/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	*	TAG	DEFICIENCY)		DATE
	dated 6/15/11, indicated						
	"6/14/11	<i>a</i> 1105					
	(11:05 A.I	M.) Res was					
	crawling of	on floor at					
	nurse						
	stationP	revention					
	devices in	use prior to					
	fall: (The	form was					
	blank)N	ew					
	intervention	on: check					
	(indicated	by					
	checkmar	k) safety					
	devices fo	r					
	positionin	g/functioning					
	Allow res	time to stand					
	& stretch,	then reattach					
	safety dev	ices"					
	An Accide	ent					
	Investigat	ion Form					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		A. BU	ILDING	NSTRUCTION 00	(X3) DATE S COMPL 08/24/2	ETED		
	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S TY INC INDIANAPOLIS, IN46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Unusual C	Occurences						
	(sic)," date	ed 6/14/11,						
	indicated	"Was at						
	nurses sta	tion charting						
	when a res	s from 500 hall						
	walked by	and said res						
	crawling of	on floor. found						
	res on all	fours crawling						
	around on	flooralarm						
	did not so	und during the						
	fallfoun	d on floor						
	unwitness	edRes was						
	crawling	.The footwear						
	at the time	e of the						
	incident w	vas:TED						
	(antithron	nbolytic						
	devices) h	ose - had						
	slippers or	n but took off						
	prior to cr	awling"						
	Document	tation was						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		Ì	ILDING	NSTRUCTION 00	(X3) DATE COMP 08/24/2	LETED	
	PROVIDER OR SUPPLIER	II S ALTH AND LIVING COMMUNITY	-	1380 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	lacking re	lated to new					
	interventions to						
	implemen	t to prevent					
	falls after	the 6/14/11					
	fall.						
	An undate	ed resident fall					
	care plan	provided by					
	the ADON	N indicated					
	"allow res	time to stand					
	& stretch,	then re-attach					
	safety dev	rices."					
	Interview	on 8/23/11 at					
	9:40 A.M	., with UM #1					
	indicated	documentation					
	was lackii	ng of the					
	resident b	eing stood and					
		to prevent falls.					
		•					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			IULTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE SUR COMPLETE	D	
		155327	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	08/24/2011	
NAME OF F	PROVIDER OR SUPPLIER				COUNTY LINE RD S		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	'INC	INDIAN	APOLIS, IN46227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	CC	(X5) OMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Nurses' no	otes indicated					
	the resident released the						
	seat belt and/or						
	attempted	to stand					
	unassisted	l on 6/15/11,					
	6/16/11, 6	7/18/11,					
	6/20/11, 6/24/11,						
	6/25/11, a	nd 6/26/11.					
	A nurses'	note, dated					
	6/29/11 at	5:45 P.M.,					
	indicated	"While in the					
	dining roc	om helping					
	another re	siden [sic] w/					
	(with) the	ir alarm					
	sounding.	After getting					
	that reside	ent settled this					
	narrator [s	sic] heard					
	another al	arm sounding					
	and it was	this res trying					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		A. BUI	ILDING	NSTRUCTION 00	(X3) DATE SU COMPLE 08/24/20	TED	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S	00/2 1/20	
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	INC	INDIAN	APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE	
	to crawl o	ut of the w/c.					
	This narrator [sic] ran to						
	help the res and was						
	unable to	lift the res					
	alone so tl	his narrator					
	[sic] assist	ted the res and					
	called for help0 (no)						
	areas of re	edness or injury					
	noted"						
	An "Intero	disciplinary					
	Team Mee	eting Fall					
	Intervention	ons" form,					
	dated 6/30	0/11, indicated					
	"6/29/11	@ 5:45 P.M.,					
	Res was a	ssisted to floor					
	p (after) b	eing seen					
	attempting	g to crawl on					
	floorWit	tnessedPreve					
	ntion devi	ces in use prior					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
ANDTLAN	OI CORRECTION	155327	1	LDING	00	08/24/2	
NAME OF T	PROVIDER OR SUPPLIER	<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		SALTH AND LIVING COMMUNITY	INC	1	COUNTY LINE RD S		
(X4) ID		TATEMENT OF DEFICIENCIES	T	ID	APOLIS, IN46227		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to fall: (T	The form was					
	blank)N	[ew					
	interventi	on: 15 min					
	checks (in	ndicated by					
	checkmar	k)Keep res					
	out of MD	OR until fully					
	staffed"						
	An Accide	ent					
	Investigat	ion Form					
	Unusual C	Occurences					
	(sic)," dat	ed 6/30/11,					
	indicated	"Was					
	assisting a	another res					
	whose ala	rm was					
	sounding	back into their					
	chair whe	n I heard					
	(Resident	name) alarm					
	sounding.	I turned and					
	saw that h	ne had					

011
(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		A. BUI	ILDING	onstruction 00	(X3) DATE S COMPL 08/24/20	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/24/20	511
	PROVIDER OR SUPPLIER		/ IN O		COUNTY LINE RD S		
(X4) ID		ALTH AND LIVING COMMUNITY TATEMENT OF DEFICIENCIES	INC	ID	APOLIS, IN46227		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	λΤΕ.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	when out						
	roomlov	ver the					
	bedInstruct staff to use						
	safe footw	vear for					
	resident	Attach bells to					
	lap robe o	r blanket"					
	1						
	 An undate	ed resident fall					
	_	provided by					
		•					
	_	N indicated					
	Res is no	C					
	MDR for	meals until DR					
	is fully sta	affed c (with)					
	workers a	ssigned to					
	serve mea	.ls"					
	 Nurses' no	otes indicated					
		nt released seat					
	belt freque	ently, leaned					
	forward in	n wheelchair					

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155327	A. BUI	LDING	00	COMPLETED 08/24/2011
		199927	B. WIN	_	ADDRESS SITE STATE SINCODE	00/24/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S	
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	INC	1	IAPOLIS, IN46227	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	and reach	ing to floor,				
	and/or trying to stand					
	unassisted on 6/30/11,					
	7/1/11, 7/2	2/11, 7/3/11,				
	7/4/11, 7/6	6/11, 7/11/11,				
	7/13/11, 7/14/11,					
	7/15/11, 7/16/11, and					
	7/20/11.					
	A nurses'	note, dated				
	7/30/11 at	6:00 A.M.,				
	indicated	"At 5:05 AM,				
	resident w	as sitting in				
	wheelchai	r with lap belt				
	in place. F	Resident				
	removed s	safety belt and				
	was witne	essed sliding				
	from the c	chair to the				
	floorRei	moved lap belt				
	several tir	nes during the				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		155327	B. WII	NG		08/24/2	2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	INC		APOLIS, IN46227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	AIE	DATE
	night and	tried to get out					
	of chair. F	Res was					
	transferre	d to recliner					
	and made	several					
	attempts t	o climb over					
	the side of	f the chairRes					
	was not in	ijured but he					
	did have a	red area to his					
	lower bac	k and					
	buttocks	."					
	An "Interd	disciplinary					
	Team Mee	eting Fall					
	Interventi	ons" form,					
	dated 8/1/	11, indicated					
	"7/30/11	@ 0510 (5:10					
	A.M.), In	front of nurses					
	stationV	VitnessedPrev					
	ention dev	vices in use					
	prior to fa	ll: Physical					
	•						

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION		(X3) DATE S COMPL	
AND FLAIN	OI CORRECTION	155327	A. BUI B. WIN	LDING	00		08/24/2	
			B. WIN		DDRESS, CITY, STATE,	ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1	COUNTY LINE RD			
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNI	TY INC	INDIAN	APOLIS, IN46227			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR			(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	O THE APPROPRIAT	E	COMPLETION DATE
	Restraint	Personal						
	Safety Ala	armNew						
	intervention	on: Aides						
	check (indicated by							
	checkmark) functioning							
	of safety devices; wait							
	until later to get up							
	(indicated	by arrow) in						
	AM15 n	nin checks						
	(indicated	by						
	checkmarl	k); dysem [sic]						
	in w/c"							
	There was	s no Accident						
	Investigat	ion Form						
	Unusual C	Occurences						
	(sic)" prov	vided for						
	review.							
	An undate	ed resident fall						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	O2QM1	1 Facility I	D: 000220	If continuation sh	eet Pa	ge 56 of 73

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327		A. BUI	ILDING	NSTRUCTION 00	(X3) DATE S COMPLE 08/24/20	ETED	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	00/24/20	/11
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	'INC	1	COUNTY LINE RD S APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	(X5) COMPLETION DATE
	care plan	provided by					
	the ADON indicated						
	document	ation was					
	lacking re	lated to any					
	new interv	ventions					
	implemen	ted to prevent					
	falls after the 7/30/11						
	fall.						
	A nurses'	note, dated					
	8/2/11 at 8	3:00 P.M.,					
	indicated	"Res removed					
	self releas	e belt - fell to					
	floor to (R	(right) side -					
	no injury	"					
	Document	tation was					
	lacking re	lated to the					
	PSA being	g in place and					
	functionin	g at the time of					
	the fall.	-					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	(X3) DATE S COMPL 08/24/2	ETED		
	PROVIDER OR SUPPLIER SITY HEIGHTS HEA	LALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INC INDIANAPOLIS, IN46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	An "Intero	disciplinary						
	Team Meeting Fall							
	Interventi	ons" form,						
	dated 8/3/	11, indicated						
	"8/2/11	@ 2005 (8:05						
	P.M.),Prevention							
	devices in	use prior to						
	fall: (The	form was						
	blank)N	ew						
	intervention	on: (The form						
	was blank)Staff to						
	assist res t	to stand &						
	stretch q4	o (every 4						
	hours) WA	A (with						
	assistance) as res						
	allows"							
	There was	s no Accident						
	Investigat	ion Form						

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155327	A. BUILDING 00 COMPLETED 08/24/2011				
		100027	B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	00/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	COUNTY LINE RD S		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	INC	INDIAN	IAPOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	Unusual C	Occurences					
	(sic)" provided for						
	review.						
	A resident	t care plan,					
	dated 8/3/	11, indicated					
	"Res is a	at risk for falls					
	d/t (due to) decreased					
	safety awa	areness15					
	min check	as x 72 hrs;					
	alarming s	self-release seat					
	belt; dyse	m [sic] in w/c					
		er; anti-tippers					
		w/c; PSA in					
	w/c, reclin	,					
	frequent r	ounds to assess					
	for safety	& comfort;					
	monitor fo	or changes and					
	f/u (follov	v up) with MD					
	as needed	staff to assist					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	(X3) DATE COMPI 08/24/2	LETED		
	PROVIDER OR SUPPLIER	II ALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE	
	res to stan	d & stretch						
	every routinely while							
	awake as l	he allows"						
	An "Interd	disciplinary						
	Team Mee	eting Fall						
	Interventions" form,							
	dated 8/4/	11, indicated						
	"8/3/11	@ 2000 (8:00						
	P.M.)Pr	evention						
	devices in	use prior to						
	fall: (The	form was						
	blank)N	ew						
	intervention	on: Ensure						
	PSA is							
	functionin	ıgStaff						
	education	" There were						
	no nurses'	notes related						
	to this fall							

l ´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155327	A. BUI	LDING	00	COMPLETE: 08/24/2011	D
		133327	B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	00/24/2011	
NAME OF P	PROVIDER OR SUPPLIER			1	COUNTY LINE RD S		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY I	NC	INDIAN	IAPOLIS, IN46227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) OMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE SS	DATE
	There was	s no Accident					
	Investigat	ion Form					
	Unusual C	Occurences					
	(sic)" prov	vided for					
	review.						
	A resident	t care plan,					
	dated 8/3/	11, indicated					
	"8/4/11 St	aff to check					
	PSA for pa	roper					
	placement	t & functioning					
	- personal	safety alarm in					
	hed and w	heelchair"					
	COUNTIN II						
	A nurses'	note, dated					
		4:00 A.M.,					
		,					
	indicated "Res was observed attempting to						
	stand fron	n w/c in hall.					
	Res yelled	i out and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		A. BUI	ILDING	NSTRUCTION 00	(X3) DATE S COMPLE 08/24/20	ETED	
NAME OF P	PROVIDER OR SUPPLIER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/24/20	511
		ALTH AND LIVING COMMUNITY	1380 E COUNTY LINE RD S Y INC INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	slowly fel	l to floor to (L)					
	side. PSA	lap belt had					
	sounded f	ive minutes					
	prior to in	cident but did					
	not sound	at the time of					
	fall. 0 (no)) apparent					
	injuries'	•					
	-						
	There was	s no					
	"Interdisc	iplinary Team					
	Meeting F	fall					
	Intervention	ons" form					
	provided f	for review.					
	1						
	There was	s no Accident					
	Investigat	ion Form					
	Unusual Occurences						
	(sic)" provided for review.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155327		A. BUI	ILDING	onstruction 00	(X3) DATE S COMPL 08/24/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/24/2	011
	PROVIDER OR SUPPLIER		(IN IO	1380 E	COUNTY LINE RD S		
(X4) ID		ALTH AND LIVING COMMUNITY TATEMENT OF DEFICIENCIES	INC	ID	APOLIS, IN46227		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		t care plan,					
		11, indicated					
	document						
	lacking re	lated to any					
	new interv	ventions being					
	implemen	ted to prevent					
	falls after	the 8/4/11 4:00					
	A.M. fall.						
	A nurses'	note, dated					
	8/4/11 at 1	12:00 P.M.,					
	indicated	"Res fell today					
	at 11:05 A	M. Was sitting					
	in hall out	side room.					
	Found on	buttocks					
	(slightly o	on (L) hip) on					
	floor c (w	ith) back					
	against w/c seatFrequently undoes						
		elt to w/c &					
	,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER	ALTH AND LIVING COMMUNITY	INC	1380 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S APOLIS, IN46227	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	attempts t	o crawl on					
	floor0 (1	no) new					
	injuries no	oted per					
	assessing	nurse"					
	Document	tation was					
	lacking to	indicate					
	alarms we	ere in place and					
	functionin	ng.					
	An "Interd	disciplinary					
	Team Mee	eting Fall					
	Interventi	ons" form,					
	dated 8/4/	11, indicated					
	"8/3/11	@ 11:05 A.M.					
	Sitting in	hall on					
	buttocks	.Prevention					
	devices in	use prior to					
	fall: (The	form was					
	blank)N	ew					
	intervention	on: Res kept					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155327	B. WIN			08/24/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S		
UNIVERS	SITY HEIGHTS HEA	ALTH AND LIVING COMMUNITY	INC	1	APOLIS, IN46227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	DATE
	w/in (within) view of						
	staffOT screen for						
	positionin	g"					
	_						
	There was	s no Accident					
	Investigat	ion Form					
	Unusual C	Occurences					
	(sic)" prov	vided for					
	review.						
	A resident	care plan,					
	dated 8/3/	11, indicated					
	"8/4/11 O	T screen for					
	positionin	g"					
	•	tation was					
	lacking to	address					
		ne resident					
		w of the staff.					
	willin vie	w of the stall.					
	A nurses'	note, dated					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE COMPL	LETED		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/24/2	.011	
	PROVIDER OR SUPPLIER		1380 E COUNTY LINE RD S					
		ALTH AND LIVING COMMUNITY	INC	<u> </u>	APOLIS, IN46227		(7/5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
	8/6/11 at 8:00 P.M., indicated "This nurse							
	doing 15 i	min check						
	(indicated	by						
	checkmar	k) found						
	resident of	n floor of						
	resident's	room between						
	chair and	bed on knees.						
	Resident l	nad a large BM						
	(bowel mo	ovement) and						
	brief was	open et tangled						
	in legs/fee	et"						
	Document	tation was						
	lacking to	indicate if						
	alarms we	ere in place and						
	functionin	g at the time of						
	the fall.							
	An "Interd	disciplinary						
	Team Mee							
		_						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CL14 IDENTIFICATION NUMBER:		MULTIPLE CO JILDING	NSTRUCTION 00		DATE SURVEY COMPLETED
	155327		B. WI	NG			3/24/2011
NAME OF I	PROVIDER OR SUPPLIEF	- {		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S			
UNIVER	SITY HEIGHTS HEA	ALTH AND LIVING COMM	MUNITY INC				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAY (EACH CORRECTIVE A CROSS-REFERENCED DEFICIE	TO THE APPROPRIATE	(X5) COMPLETION DATE
	_	ons" form,					
	dated 8/8/	11, indicated					
	"8/6/11 @ 8 P.M.						
	found on	floor between					
	chair & bo	ed on					
	kneesPr	evention					
	devices in	use prior to					
	fall: (The form was						
	blank)N	lew					
	interventi	on: Res					
	encourage	ed to stay up					
	(indicated	l by arrow)					
	until hypr	notic givenO	T				
	to eval (ev	valuate) et tx					
	(treat) as i	indicated"					
	There was	s no Accident					
	Investigat	ion Form					
	Unusual (Occurences					
	(sic)" prov	vided for					
FORM CMS-2	L 2567(02-99) Previous Version	ons Obsolete Event	ID: O2QM1	11 Facility I	D: 000220	If continuation sheet	Page 67 of 73

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	(X3) DATE : COMPL 08/24/2	ETED	
	NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY I			1380 E	COUNTY LINE RD S APOLIS, IN46227	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	review.						
	A resident	care plan,					
	dated 8/3/	11, indicated					
	"8/8/11 St	aff to					
	encourage	e res to stay up					
	until sche	duled					
	Trazadone	e (an					
	antidepres	ssant used for					
	insomnia)	(initiated					
	8/6/11); O	T to eval &					
	treat as in	dicated					
	(screening	g completed-					
	-wheelcha	ir positioning					
	evaluation	n); assist to					
	recliner in	room					
	(afternoon	n) for rest					
	period as						
	tolerated/a	allowed"					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327			ILDING	NSTRUCTION 00	<u>`</u>	E SURVEY PLETED 2011			
	PROVIDER OR SUPPLIER	R ALTH AND LIVING COMMUNITY	'INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INC INDIANAPOLIS, IN46227					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	An Occup	oational							
	Therapy "	'Plan of Care,"							
	dated 8/8/	11, indicated							
	"Curren	tly, patient							
	utilizing e	elevated foot							
	pedals wi	th foot cradle							
	while in hallway with s/s								
	signs/syr	nptoms)							
	scooting l	nips/buttocks							
	forward in	n order to get							
	up from v	v/c. He did,							
	however,	c/o (complain							
	of) needir	ng to use the							
	restroom.	Не							
	demonstra	ates ability to							
	remove P	SA lap belt							
	without needing prompts								
	- fall risk.	"							
	Documen	tation was							
	lacking re	elated to							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	INSTRUCTION 00	(X3) DATE :		
AND I LAN	or courternor	155327	A. BUI B. WIN	ILDING NG		08/24/2	
NAME OF P	PROVIDER OR SUPPLIER		D. WII		ADDRESS, CITY, STATE, ZIP CODE	ļ	
		ALTH AND LIVING COMMUNITY	INC	1	COUNTY LINE RD S APOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	AI OLIO, IIV+0221		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	NTE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ndations for					
	change in	w/c					
	positionin	g.					
l	•						
	Nurses' no	otes indicated					
	the resider	nt attempted to					
	stand with	out assistance,					
	climb out	of the recliner,					
	and get ou	it of chair,					
	and/or unf	fasten seat belt					
	on 8/12/11	1, 8/13/11,					
	8/17/11, 8	/20/11, and					
	8/23/11.	,					
	0/ 2 3/11.						
	Interview	on 8/23/11 at					
		., with UM #1					
	indicated	the resident					
	had "decre	eased safety					
	awareness	s" and staff					
	toileted th						
	tonetea th	t resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		A. BU	ILDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER	 	B. WII	1380 E	DDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD S APOLIS, IN46227	<u> </u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	"every co	uple of hours"					
	but indica	ted there was					
	no docum	entation of a					
	toileting s	chedule. She					
	indicated	there were					
	several in	terventions that					
	were not i	new but had					
	been in pl	ace. She					
	indicated	the resident					
	should ha	ve been					
	monitored	l in activities					
	and shoul	d not have					
	been "left	unattended in					
	the dining	room." She					
	stated "I u	inderstand your					
	concerns.'	1					
	Review or	n 8/23/11 at					
	11:05 A.N	I., of a facility					
	policy and	d procedure,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155327		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 08/24/20	ETED	
	PROVIDER OR SUPPLIER	LALTH AND LIVING COMMUNITY	B. WING GG/24/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	dated 5/02	2 and revised					
	6/05, prov	rided by the					
	ADON, ic	lentified as					
	current, ar	nd titled "Fall					
	Prevention	n Program"					
	indicated	"Document					
	immediate	e interventions					
	implemen	ted to prevent					
	another fa	lla plan of					
	care will b	e established					
	to include	individualized					
	intervention	ons for those					
	residents v	who are					
	evaluated	to be at risk"					
	3.1-45(a)((2)					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327	(X2) MULTIPL A. BUILDING B. WING	ING		(X3) DATE SURVEY COMPLETED 08/24/2011	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY INC							
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO TH	N SHOULD BE	(X5) COMPLETION DATE	